Program A: Medical Vendor Administration

PROGRAM DESCRIPTION

The mission of the Medical Vendor Administration Program is to administer the Medicaid Program and ensure operations are in accordance with federal and state statues, rules and regulations.

The goals of Medical Vendor Administration Program are:

1. To process claims from Medicaid providers in accordance with state and federal regulations.
2. To process Medicaid applications s in accordance with state and federal regulations.
3. To annually license and survey health care facilities providing services to Louisiana citizens.
4. To enroll and provide healthcare coverage for uninsured children under LaCHIP according to the approved State plan.

The Medical Vendor Administration Program includes the following activities: Medicaid Management Information System, Medicaid Eligibility Determinations, Program Integrity, and Health Standards and other executive management sections.

OBJECTIVES AND PERFORMANCE INDICATORS

Unless otherwise indicated, all objectives are to be accomplished during or by the end of FY 2000-2001. Performance indicators are made up of two parts: name and value. The indicator name describes what is being measured. The indicator value is the numeric value or level achieved within a given measurement period. For budgeting purposes, performance indicator values are shown for the prior fiscal year, the current fiscal year, and alternative funding scenarios (continuation budget level and Executive Budget recommendation level) for the ensuing fiscal year (the fiscal year of the budget document).

The objectives and performance indicators that appear below are associated with program funding in both the Base Executive Budget and Governor's Supplementary Recommendations for FY 2000-01. Specific information on program funding is presented in the financial sections that follow performance tables.

1. (KEY) Through the Medicaid Management Information System, to operate an efficient Medicaid Claims processing system by processing at least 98% of submitted claims within 30 days of receipt.

Strategic Link: *This objective implements Goal 1, Objective 1.1 of the strategic plan: To process 100% of submitted claims within 30 days.*

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE INDICATOR VALUES					
		YEAREND PERFORMANCE STANDARD FY 1998-1999	ACTUAL YEAREND PERFORMANCE FY 1998-1999	ACT 10 PERFORMANCE STANDARD FY 1999-2000	EXISTING PERFORMANCE STANDARD FY 1999-2000	AT CONTINUATION BUDGET LEVEL FY 2000-2001	AT RECOMMENDED BUDGET LEVEL FY 2000-2001
K	Percentage of total claims processed within 30 days	99%	96%	98%	98%	98%	98%
S	Average processing time (in days)	9.0	9.2	9.0	9.0	9.0	9.0

[1] This performance indicator did not appear under Act 19 and therefore had no performance standard for FY 1998-99.

[2] This performance indicator did not appear under Act 10 and therefore had no performance standard for FY 1999-2000.

GENERAL PERFORMANCE INFORMATION						
PERFORMANCE INDICATOR NAME		PRIOR YEAR ACTUAL FY 1994-95	PRIOR YEAR ACTUAL FY 1995-96	PRIOR YEAR ACTUAL FY 1996-97	PRIOR YEAR ACTUAL FY 1997-98	PRIOR YEAR ACTUAL FY 1998-99
Total number of claims processed	[1]	42,349,291	40,612,108	39,111,873	37,702,094	38,659,305
Percentage of claims processed within 30 days	[1]	99.3%	99.5%	98.3%	99.0%	98.2%

[1] In previous fiscal years and in LaPas, the number reported was actually for "claims paid." The number has been corrected. It is expected that there will be approximately 39,045,899 claims processed in FY 2000-2001. This former indicator is being reported as general performance information now because it is a number which the Bureau of Health Services Financing has no control, i.e., it represents all claims that are submitted by billing entities.

2. (KEY) Through the Medicaid Management Information System activity, to operate an efficient Medicaid Claims processing system by editing 100% of nonexempt claims for Third Party Liability (TPL) and Medicare coverage.

Strategic Link: *This objective implements Goal 1, Objective 1.1 of the strategic plan: To process 100% of submitted claims within 30 days and edit all claims for TPL by June 30, 2003.*

Explanatory Note: TPL refers to "Third Party Liability." The Bureau of Health Services Financing is required to identify all claims for which third party insurance exists and where applicable, make a reduced payment based on what the third party insurance pays. Certain Medicaid claims are exempt from the initial edit for TPL. In those instances the agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from the liable third party. This process is known as "pay and chase." Exempt claims include those for labor and delivery, postpartum care, prenatal care, preventive pediatric services, and pharmacy services. As Medicaid claims are processed those that are exempt from TPL are identified. The remaining claims are referred to in the General Performance Information table as the "number of claims available for TPL processing."

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE INDICATOR VALUES					
		YEAREND PERFORMANCE STANDARD FY 1998-1999	ACTUAL YEAREND PERFORMANCE FY 1998-1999	ACT 10 PERFORMANCE STANDARD FY 1999-2000	EXISTING PERFORMANCE STANDARD FY 1999-2000	AT CONTINUATION BUDGET LEVEL FY 2000-2001	AT RECOMMENDED BUDGET LEVEL FY 2000-2001
K	Number of TPL claims processed [1]	4,499,650	4,507,518	3,190,000	3,190,000	4,550,000	4,550,000
K	Percentage of TPL claims processed through edits [2]	100%	100%	100%	100%	100%	100%
S	TPL recovery amount	Not applicable [3]	$6,146,020	$5,040,000	$5,040,000	$5,040,000	$5,040,000

[1] The "number of TPL claims processed" refers to the portion of those claims requiring processing for which third party insurance or Medicare coverage was actually available/applicable.

[2] The "percent of TPL claims processed through edits" is the percent of TPL claims processed for which the Bureau of Health Services Financing reduced payments, or avoided full Medicaid payment.

[3] This performance indicator did not appear under Act 19 and therefore had no performance standard for FY 1998-99.

GENERAL PERFORMANCE INFORMATION					
PERFORMANCE INDICATOR NAME	PRIOR YEAR ACTUAL FY 1994-95	PRIOR YEAR ACTUAL FY 1995-96	PRIOR YEAR ACTUAL FY 1996-97	PRIOR YEAR ACTUAL FY 1997-98	PRIOR YEAR ACTUAL FY 1998-99
Number of claims available for TPL processing	29,349,291	26,942,221	25,211,042	23,459,482	23,699,339
Number of TPL claims processed	3,641,000	5,270,709	4,810,782	4,307,087	4,507,518
Percentage of TPL claims processed and cost avoided of [1]	8.6%	12.9%	12.3%	11.4%	11.7%

[1] The "percent of TPL claims processed and cost avoided of the total number of claims processed" is the number of TPL claims processed divided by the total number of claims.

3. (KEY) Through the Medicaid Eligibility Determination activity, to provide Medicaid eligibility determinations and administer the program within federal regulations by processing 98% of applications timely.

Strategic Link: *This objective implements Goal II, Objective II.1 of the strategic plan: To provide Medicaid Eligibility Determinations and administer the program within federal regulations by processing 98% of applications (within federal guidelines 45 and/or 90 days), by June 30, 2003.*

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE INDICATOR VALUES					
		YEAREND PERFORMANCE STANDARD FY 1998-1999	ACTUAL YEAREND PERFORMANCE FY 1998-1999	ACT 10 PERFORMANCE STANDARD FY 1999-2000	EXISTING PERFORMANCE STANDARD FY 1999-2000	AT CONTINUATION BUDGET LEVEL FY 2000-2001	AT RECOMMENDED BUDGET LEVEL FY 2000-2001
K	Percentage of applications processed timely	97%	100%	99%	99%	98%	98%
S	Number of applications processed timely	202,119	237,990	259,257	259,257	259,257	249,500

GENERAL PERFORMANCE INFORMATION					
PERFORMANCE INDICATOR NAME	PRIOR YEAR ACTUAL FY 1994-95	PRIOR YEAR ACTUAL FY 1995-96	PRIOR YEAR ACTUAL FY 1996-97	PRIOR YEAR ACTUAL FY 1997-98	PRIOR YEAR ACTUAL FY 1998-99
Percentage of applications processed timely	Not available	97.3%	99.0%	99.1%	99.6%
Number of recipients eligible for program	831,182	817,897	779,142	757,040	775,787
Average number of recipients per month	632,867	630,129	599,724	574,793	578,871
Number of applications taken annually	Not available	Not available	Not available	215,292	239,037
Number of application centers	Not available	Not available	Not available	534	534

4. (KEY) Through the Health Standard activity to perform 100% of required state licensing and complaint surveys of healthcare facilities and federally mandate certification of health care providers participating in Medicare and/or Medicaid.

Strategic Link: *This objective implements Goal V, Objective V.1 of the strategic plan: To perform 100% of required state licensing and complaint surveys of healthcare facilities and federally mandated certification of health care providers participating in Medicare and/and or Medicaid through June 30, 2003.*

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE INDICATOR VALUES					
		YEAREND PERFORMANCE STANDARD FY 1998-1999	ACTUAL YEAREND PERFORMANCE FY 1998-1999	ACT 10 PERFORMANCE STANDARD FY 1999-2000	EXISTING PERFORMANCE STANDARD FY 1999-2000	AT CONTINUATION BUDGET LEVEL FY 2000-2001	AT RECOMMENDED BUDGET LEVEL FY 2000-2001
S	Number of facilities out of compliance	285	516	Not applicable [1]	525	516	525
S	Number of facilities sanctioned [2]	76	131	Not applicable [1]	135	131	135
S	Number of facilities terminated [3]	20	13	Not applicable [1]	12	13	12
K	Percentage of facilities out of compliance	Not applicable [4]	13.7%	Not applicable [1]	13.0%	13.7%	13.0%

[1] This performance indicator did not appear under Act 19 and therefore had no performance standard for FY 1998-99.

[2] Sanction are remedies or penalties applied to facilities found out of compliance with state standards or federal regulations. Available sanctions include: termination of the provider agreement; denial of payment (Medicaid and/or Medicare) for new admissions; civil money penalties; state on-site monitoring (random or 24 hours); temporary management; transfer of residents/patients/clients; directed plan of correction; or directed in-service training.

[3] The number of terminated facilities (due to adverse action being taken against a facility found out of compliance) is difficult to determine because the state has no control over facilities which do no come back into compliance. This sections also encourages facilities to come back into compliance as this would be the best for Medicaid clients/patients under their care. Termination is invoked for continued failure to correct deficient practices.

[4] This performance indicator did not appear under Act 10 and therefore had no performance standard for FY 1999-2000.

GENERAL PERFORMANCE INFORMATION					
PERFORMANCE INDICATOR NAME	PRIOR YEAR ACTUAL FY 1994-95	PRIOR YEAR ACTUAL FY 1995-96	PRIOR YEAR ACTUAL FY 1996-97	PRIOR YEAR ACTUAL FY 1997-98	PRIOR YEAR ACTUAL FY 1998-99
Total number of facilities (unduplicated)	4,022	3,931	3,973	4,022	3,772
Number of certified facilities	2,668	2,563	2,578	2,536	2,333
Number of licensed facilities	2,640	2,692	2,732	2,826	2,628
Number of facilities out of compliance	97	169	258	318	516

5. (KEY) To achieve 80% or greater enrollment of children (birth through 18 years of age) living below 200% of the Federal Poverty Level (FPL) who are potentially eligible for services under Title XIX and Medicaid expansion under Title XXI of the Social Security Act.

Strategic Link: *This objective implements Goal IX, Objective IX.1 of the strategic plan: Through an outreach effort to begin November 1998, to identify and enroll 75% of the uninsured children (birth through 18 years of age) eligible for Medicaid and health insurance coverage under either Title XIX or Title XXI of the Social Security Act.*

Explanatory Note: Title XIX of the Social Security Act is a program of national health assistance funded by the federal government and the states. The program covers low-income individuals and their families who are aged, blind or disabled, and members of families with dependent children. Title XXI allow states to expand coverage of Medicaid health assistance to children who live in families with incomes up to 200% of the federal poverty level (FPL). Louisiana is currently using Title XXI to serve children in families with incomes up to 150% of the FPL.

LEVEL	PERFORMANCE INDICATOR NAME	PERFORMANCE INDICATOR VALUES					
		YEAREND PERFORMANCE STANDARD FY 1998-1999	ACTUAL YEAREND PERFORMANCE FY 1998-1999	ACT 10 PERFORMANCE STANDARD FY 1999-2000	EXISTING PERFORMANCE STANDARD FY 1999-2000	AT CONTINUATION BUDGET LEVEL FY 2000-2001	AT RECOMMENDED BUDGET LEVEL FY 2000-2001
S	Potential eligibles below 200% FPL [1]	Not applicable [2]	474,875	Not applicable [3]	474,875	474,875	474,875
S	Number of children enrolled as Title XXI	28,350	18,598 [4]	28,350	39,075	39,075	39,075
S	Number of children enrolled as Title XIX	44,162	337,459 [4,5]	44,162	359,427	359,427	359,427
K	Total number of children enrolled	Not applicable [2]	356,057 [4]	Not applicable [3]	398,502	398,502	398,502
K	Percentage of children enrolled	71.6%	75.0%	78.0%	83.9%	83.9%	83.9%
S	Number of children remaining uninsured	Not applicable [2]	118,818	Not applicable [3]	76,373	76,373	76,373
K	Average cost per Title XXI enrollee per year	Not applicable [2]	Not available [6]	Not applicable [3]	$1,106	$1,106	$1,186
K	Average cost per Title XIX enrollee per year	Not applicable [2]	Not available [6]	Not applicable [3]	$885	$885	$950

[1] The number of potential eligibles is an estimate provided by Dr. Kenneth Thorpe, Tulane University School of Public Health, who was appointed to the Governor's Task Force on Children's Health Insurance.

[2] This performance indicator did not appear under Act 19 and therefore had no performance standard for FY 1998-99.

[3] This performance indicator did not appear under Act 10 and therefore had no performance standard for FY 1999-2000.

[4] This figure represents eight months of implementation.

[5] The number of children enrolled in Title XIX prior to the start of LaCHIP outreach was 315,271 or 66.4% of the potentially eligible population. Therefore, there were 159,604 children uninsured at that time.

[6] Data for this performance indicator was not available as a yearly figure in FY 1998-99, as the program only captured this information on a monthly basis. The average cost for Title XXI enrollee was $54 per month in 1998-99, and Title XIX cost per enrollee was $50 per month.

RESOURCE ALLOCATION FOR THE PROGRAM

	ACTUAL 1998-1999	ACT 10 1999- 2000	EXISTING 1999- 2000	CONTINUATION 2000 - 2001	RECOMMENDED 2000 - 2001	RECOMMENDED OVER/(UNDER) EXISTING
MEANS OF FINANCING:						
STATE GENERAL FUND (Direct)	$42,483,174	$44,341,808	$44,364,912	$51,082,831	$47,159,793	$2,794,881
STATE GENERAL FUND BY:						
Interagency Transfers	374,857	0	0	0	0	0
Fees & Self-gen. Revenues	1,045,074	4,117,812	4,117,812	1,996,173	2,092,173	(2,025,639)
Statutory Dedications	0	985,909	985,909	0	0	(985,909)
Interim Emergency Board	0	0	0	0	0	0
FEDERAL FUNDS	55,768,569	64,131,984	64,814,727	68,925,716	65,912,297	1,097,570
TOTAL MEANS OF FINANCING	**$99,671,674**	**$113,577,513**	**$114,283,360**	**$122,004,720**	**$115,164,263**	**$880,903**
EXPENDITURES & REQUEST:						
Medical Vendor Administration	$99,671,674	$113,577,513	$114,283,360	$122,004,720	$115,164,263	$880,903
TOTAL EXPENDITURES AND REQUEST	**$99,671,674**	**$113,577,513**	**$114,283,360**	**$122,004,720**	**$115,164,263**	**$880,903**
AUTHORIZED FULL-TIME EQUIVALENTS: Classified	1,134	1,270	1,273	1,347	1,289	16
Unclassified	0	0	0	0	0	0
TOTAL	**1,134**	**1,270**	**1,273**	**1,347**	**1,289**	**16**

A supplemetary recommendation of $783,313, of which $340,834 is State General Fund, is included in the Total Recommended for this program. It represents full finding of the administrative component of the implematation of the new program for persons with special needs in the Medical Vendor Payments Program. This item is contingent upon Revenue Sources in excess of the Official Revenue Estimating Conference Forecast subject to Legislative approval and recognition by the Revenue Estimating Conference.

SOURCE OF FUNDING

This program is funded with General Fund, Fees and Self-generated Revenues, and Federal Funds. Fees and Self-generated Revenue are derived from licensing and certification fees, third party liability collections and miscellaneous collections, such as document copies. Federal Funds represent the federal share of the cost to administer the Medicaid program. The Statutory Dedication in the Existing Operating is the Louisiana Fund payable out of funding received pursuant to the Master Settlement Agreement reached between certain states and participating tobacco products manufacturers in December 3, 1999 (R.S. 39:32B (8), see table below for a listing of expenditures out of each Statutory Dedication fund). The Federal Share varies by type of activity, but averages about 50% of the total Medicaid administrative cost.

	ACTUAL 1998-1999	ACT 10 1999- 2000	EXISTING 1999- 2000	CONTINUATION 2000 - 2001	RECOMMENDED 2000 - 2001	RECOMMENDED OVER/(UNDER) EXISTING
Louisiana Fund	$0	$985,909	$985,909	$0	$0	($985,909)

ANALYSIS OF RECOMMENDATION

GENERAL FUND	TOTAL	T.O.	DESCRIPTION
$44,341,808	**$113,577,513**	**1,270**	**ACT 10 FISCAL YEAR 1999-2000**
			BA-7 TRANSACTIONS:
$0	$594,502	0	Carry forward of Federal Funds
$0	$0	2	Transfer of two positions from DHH Office of the Secretary on September 21, 1999
$0	$0	1	Transfer of one position from DHH Office of the Secretary on October 7, 1999
$23,104	$111,345	0	Transfer of State General Fund from DHH Office of the Secretary and the addition of matching Federal Funds to fully fund the LaCHIP School Nurse Coordination and support staff positions in the Department of Education, which were improperly funded in an amendment to the General Appropriation Bill
$44,364,912	**$114,283,360**	**1,273**	**EXISTING OPERATING BUDGET – December 3, 1999**
$291,268	$582,536	0	Annualization of FY 1999-2000 Classified State Employees Merit Increase
$290,576	$581,152	0	Classified State Employees Merit Increases for FY 2000-2001
($116)	($232)	0	Teacher Retirement Rate Adjustment
($64,611)	($202,835)	0	Risk Management Adjustment
$600,982	$1,201,964	0	Acquisitions & Major Repairs
($807,529)	($1,615,059)	0	Non-Recurring Acquisitions & Major Repairs
$0	($594,502)	0	Non-Recurring Carry Forwards
$1,650	$3,300	0	Rent in State-Owned Buildings
($6,865)	($13,730)	0	Maintenance of State-Owned Buildings
$534,588	$1,069,177	0	Salary Base Adjustment
($945,124)	($1,890,249)	0	Attrition Adjustment
($310,011)	($620,023)	(37)	Personnel Reductions
($87,611)	($175,222)	0	Salary Funding from Other Line Items
$13,683	$27,366	0	Civil Service Fees
$1,314,190	$2,992,387	32	Workload Adjustments - Initiatives required in the partial settlement of *Chisolm v. Hood*
$168,652	$337,303	0	Workload Adjustments - Increase in the Hospital Claims Audit Contract
$237,144	$474,288	0	Workload Adjustments - Increase in the Long Term Care Facility Claims Audit Contract

$250,000	$1,000,000	0	Workload Adjustments - Increase in the Fiscal Intermediary Contract
$139,155	$278,311	0	Other Annualizations - Administrative costs of 800 MR/DD Waiver Slots added to the Medical Vendor Payments program in FY 2000
$56,515	$269,118	0	Other Annualizations - Administrative costs of the eligibility expansion under the Louisiana Children's Health Insurance Program to 150% of the Federal Poverty Level in FY 2000
$224,385	$448,771	0	Other Annualizations - Move of three (3) parish and one (1) regional office
($1,431,325)	($2,862,650)	0	Other Non-Recurring Adjustments - Partial funding of the contract to upgrade the Welfare Information System (WIS) into the Medical Eligibility Determination System (MEDS)
($570,444)	($1,140,889)	0	Other Non-Recurring Adjustments - Excess funding and revenue authority for Interagency Transfers between this agency and the Department of Social Services
$4,413	$8,827	0	Other Adjustments - Reallocation of Medicaid Director and Deputy Directors positions
$0	$1,035,601	0	Other Adjustments - Reallocation of Eligibility Examiners Series
$57,270	$57,270	0	Other Adjustments - Increase in State's portion of Group Insurance Benefits for Retirees
$68,334	$68,334	0	Other Adjustments - Increase in the number of retirees on Group Insurance by fourteen (14)
$21,500	$43,000	0	Other Adjustments - Hardware for implementation of the new ISIS Human Resource System
($215,074)	($430,149)	0	Other Adjustment(s) - Decrease in expenditures due in balancing statewide Interagency Transfers
($52,262)	($52,262)	(1)	Other Technical Adjustments - Transfer one (1) position and related expenditures to the DHH Office of the Secretary for legal services
$0	$0	22	Other Technical Adjustments - Transfer twenty-two (22) positions from various agencies through out DHH to staff the Waiver Unit and the Pharmacy Unit
$3,011,548	$0	0	Net Means Of Financing Substitutions - Replace $2,025,639 in Fees and Self-generated Revenues and $985,909 in Statutory Dedications (Louisiana Fund) with State General Fund to properly align revenues with collection projections
$47,159,793	**$115,164,263**	**1,289**	**TOTAL RECOMMENDED**
($340,834)	**($783,318)**	**(14)**	**LESS GOVERNOR'S SUPPLEMENTARY RECOMMENDATIONS**
$46,818,959	**$114,380,945**	**1,275**	**BASE EXECUTIVE BUDGET FISCAL YEAR 2000-2001**
			SUPPLEMENTARY RECOMMENDATIONS CONTINGENT ON SALES TAX RENEWAL:
$0	$0	0	None
$0	**$0**	**0**	**TOTAL SUPPLEMENTARY RECOMMENDATIONS CONTINGENT ON SALES TAX RENEWAL**
			SUPPLEMENTARY RECOMMENDATIONS CONTINGENT ON NEW REVENUE:
$340,834	$783,318	14	Administrative Component of a new program for persons with special needs
$340,834	**$783,318**	**14**	**TOTAL SUPPLEMENTARY RECOMMENDATIONS CONTINGENT ON NEW REVENUE**
$47,159,793	**$115,164,263**	**1,289**	**GRAND TOTAL RECOMMENDED**

The total means of financing for this program is recommended at 100.7% of the existing operating budget. It represents 85.4% of the total request ($134,780,258) for this program. The major changes resulting in the increase of $1.3 million from the existing operating budget is the funding of the activities agreed to the partial settlement of *Chisolm v. Hood*, the re-grade of the eligibility examiners series, and the removal of part of funding added in the prior two budget cycles to upgrade the Welfare Information System (WIS) into the Medicaid Eligibility Determination System (MEDS).

PROFESSIONAL SERVICES

$933,644	Audits of Title XIX Reimbursement to Hospitals
$1,442,188	Audits of Title XIX Reimbursement to Long-term Care Facilities
$650,250	Audits of Title XIX Reimbursement to Pharmacy Providers
$680,923	Bock Psychiatric Evaluations
$200,000	Covington & Burling Litigation Costs
$457,934	Dental Claim Review and Authorization by the LSU School of Dentistry
$15,555	Eligibility Medical Examinations to Determine Disability of Applicants
$33,901,304	Fiscal Intermediary Contract
$300,000	Hospital Reimbursement Rate Re-basing Study Contract
$30,000	IBM Programmer Contract to maintain the Licensing and Certification programs on the Health Standards Miniframe
$25,000	Independent Assessments performed under contract on Waiver programs approved under Section 1915 (b)(c) of the Social Security Act
$113,689	Internal Revenue Service Computer Matching of Personal Tax Information utilized in determining Applicant Eligibility for the Medicaid program
$3,909,551	KID-MED Management Contract
$91,220	Long Tern Care Quality of Care Assessment Consultants
$42,534	Medical Eligibility Determination Team
$608,221	New Orleans Children's Hospital provides VACP Case Management
$3,146,182	Non-Emergency Medical Transportation
$65,000	Northeast Louisiana University's School of Pharmacy serves as a reference point on drug utilization reviews
$106,000	Nurse Aide Registry
$15,000	Nurses Aide Competency Testing
$80,000	Psychiatric Consultants
$25,000	Surveillance and Utilization Review Statistical Consultants
$2,328,088	Third Party Liability Collection Contract
$49,167,283	**TOTAL PROFESSIONAL SERVICES**

OTHER CHARGES

$1,786,421	Administrative Costs of LaCHIP
$1,600,000	Contract with the University of New Orleans for Information Systems Services, Assessment and Training
$160,000	Employee Licensing Training for Nursing Homes, ICF/MRs, Hospital Homes Health Agencies and Dialysis Facilities
$300,000	Hepatitis B Vaccine
$1,800	OASIS grant
$15,000	Reimbursement of Nurse Aide Training
$617,691	Reimbursement to varying organizations serving as Medicaid Enrollment Centers
$5,000	Supplemental Security Income Field Office Eligibility Determination Information

$4,485,912 SUB-TOTAL OTHER CHARGES

Interagency Transfers:

$161,979	Civil Service Fees
$45,246	DIAL Network operated by the DD Council
$72,095	Influenza Vaccine from Office of Public Health
$111,345	LaCHIP School Nurse Coordinator and support personnel housed in the Department of Education
$203,580	Life Safety Code Inspections by the State Fire Marshall
$19,084	Maintenance of State-Owned Buildings
$48,020	Payments to the Governor's Office of Women's Services for Medicaid applications processed while serving as a Medicaid Enrollment Center
$1,233,218	Payments to the Office for Citizens with Developmental Disabilities for Regional Transition Coordinators for clientele enrolling in the MR/DD Waiver program and for case management and slot monitoring of MR/DD Waiver Slots actually filled
$113,358	Rent in State-Owned Building
$2,100,746	Statewide Co-Housing of Staff with the Department of Social Services/ Office of Family Support Staff
$88,532	Supplies from the Department of Social Services Warehouse

$4,197,203 SUB-TOTAL INTERAGENCY TRANSFERS

$8,683,115 TOTAL OTHER CHARGES

ACQUISITIONS AND MAJOR REPAIRS

$1,531,364	Funding for replacement of inoperable and obsolete office and computer equipment

$1,531,364 TOTAL ACQUISITIONS AND MAJOR REPAIRS